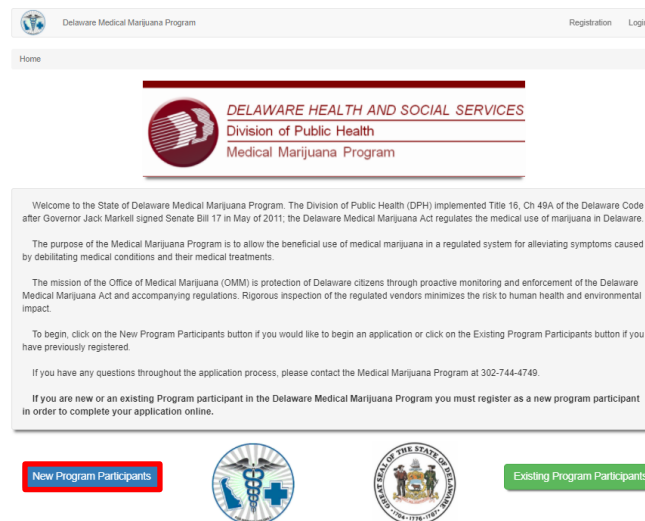


New Patient Registration and Application Guide

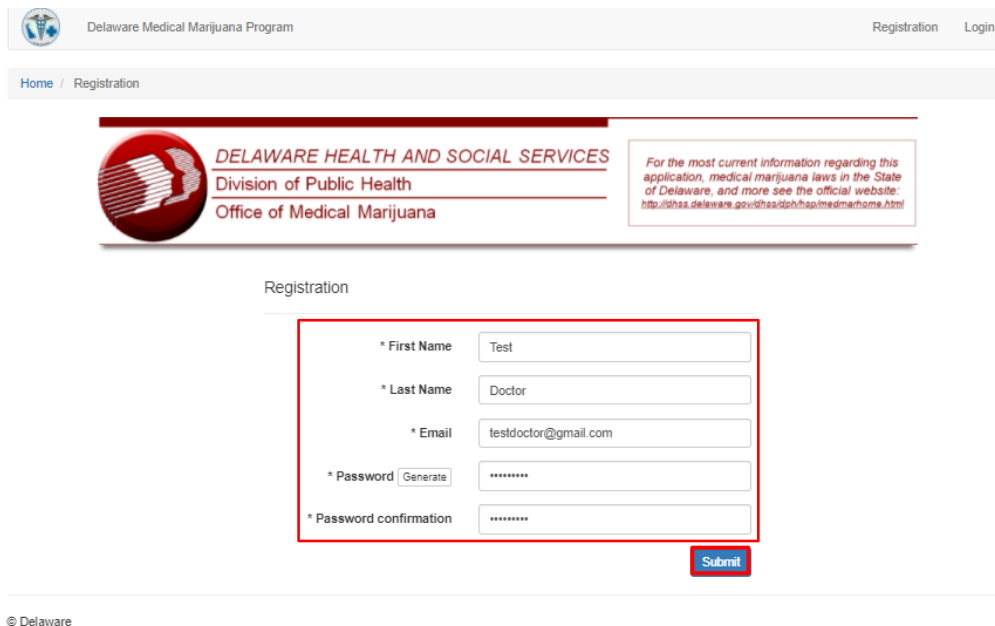
Registration: <https://delaware.biotrackthc.net/patients/actions/>

Before system use the patient must register for the system. To begin registration navigate to the patient portal and click on 'New Program Participants'.



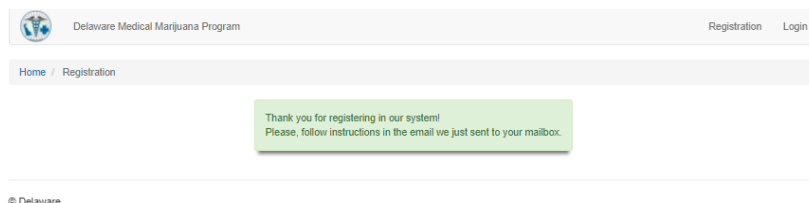
The screenshot shows the homepage of the Delaware Medical Marijuana Program. At the top, there is a navigation bar with 'Delaware Medical Marijuana Program' on the left and 'Registration' and 'Login' on the right. Below this is a 'Home' link. The main content area features the Delaware Health and Social Services logo and the text 'Division of Public Health Medical Marijuana Program'. A large text block provides information about the program, including its purpose and mission. At the bottom, there are two buttons: 'New Program Participants' (highlighted with a red box) and 'Existing Program Participants' (highlighted with a green box). There are also two circular logos: the Delaware State Seal and the Medical Marijuana Program logo.

The registration screen is displayed. On the registration screen input the First Name, Last Name, Email Address, Password and Password confirmation into the provided fields. Verify the information entered is accurate and click 'Submit' to complete the registration.

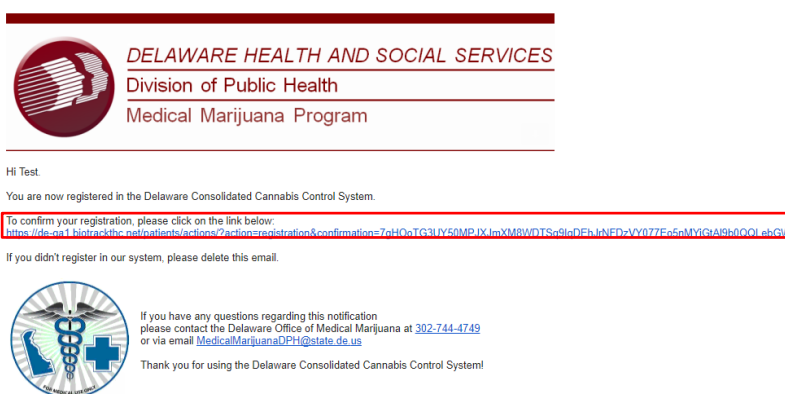


The screenshot shows the registration screen of the Delaware Medical Marijuana Program. At the top, there is a navigation bar with 'Delaware Medical Marijuana Program' on the left and 'Registration' and 'Login' on the right. Below this is a 'Home / Registration' link. The main content area features the Delaware Health and Social Services logo and the text 'Division of Public Health Office of Medical Marijuana'. A text box on the right provides information about the program and a link to the official website. Below this is a 'Registration' heading. The registration form is highlighted with a red box and contains the following fields: 'First Name' (Test), 'Last Name' (Doctor), 'Email' (testdoctor@gmail.com), 'Password' (with a 'Generate' button and a masked field), and 'Password confirmation' (with a masked field). A 'Submit' button is located at the bottom right of the form. At the bottom of the page, there is a copyright notice: '© Delaware'.

Once the registration is submitted successfully the following screen appears.

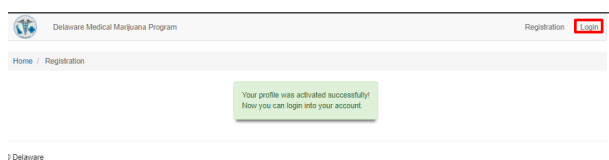


Next, navigate to your email inbox and **single click** the link in the confirmation email to confirm registration.



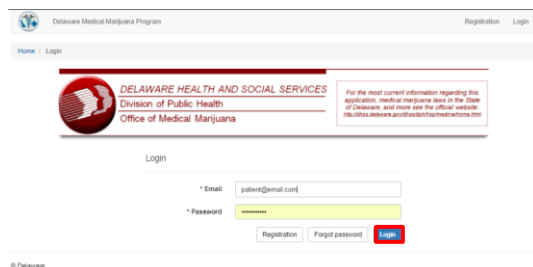
Note: The confirmation link is single use only. Be sure to only click the confirmation link once.

Clicking the link brings up confirmation message shown below. This message confirms the registration. Click on 'Login' to return to the login screen and login to the system.



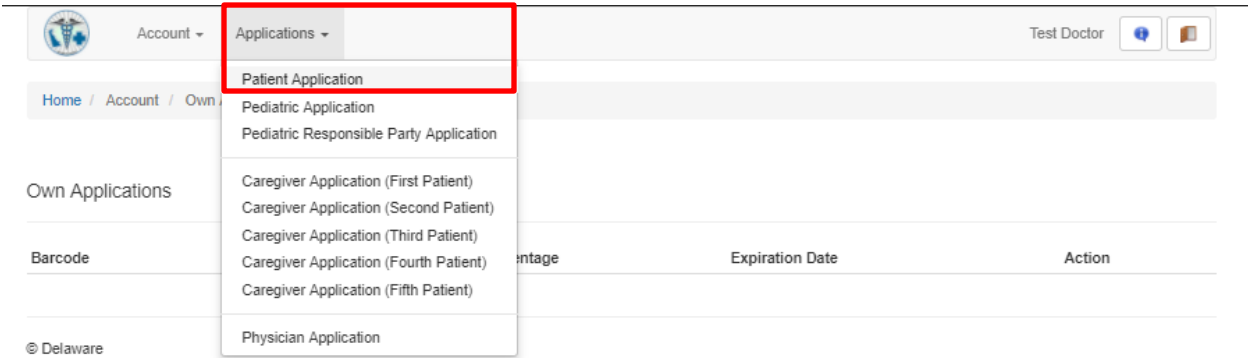
Logging into the System

On the login screen input the email and password set up during system registration and click 'Login'



Patient Application

To input a patient application, first navigate to the Applications menu and select 'Patient Application':



That will bring up the patient application:

The screenshot shows the 'Medical Marijuana Patient Application' form. It is divided into two main sections: 'Medical Marijuana Patient Application' and 'Patient Contact Information'. The first section includes a photo upload area with a '75%' width and '100%' height requirement, and two radio button options: 'New Patient' and 'Renewing Patient'. The second section includes fields for 'Last Name', 'First Name', 'Middle Name', 'Suffix', 'Address (Street)', 'Address (Apt #, P.O. Box, Suit #)', 'County', 'State', 'City', 'ZIP Code', 'Primary Phone', 'Secondary Phone', 'Email Address', and 'Date of Birth'. There are also radio button options for 'Male' and 'Female'.

Complete the following fields of the application:

- Click +Upload to select and upload a picture of the patient
- Select either New or Returning patient
- Answer 'Have you ever applied for a Medical Marijuana ID card?' Yes or No.
- Last Name – Input the patient's last name
- First Name – Input the patient's first name
- Suffix – Enter the name Suffix, if any (optional)
- Enter the patient's full address including county into the provided fields
- Enter the primary phone number for the patient and secondary number if applicable

- Enter the patient's email address
- Select the patient's gender
- Input the patients' date of birth in MM-DD-YYYY format

After inputting patient information scroll down to the Patient's Attestation Statement:

First Name <input type="text" value="A"/>		Last Name <input type="text" value="Test"/>	
Address (Street) <input type="text" value="123 4th St."/>		Address (Apt #, P.O. Box, Suit #) <input type="text"/>	
County <input type="text" value="Kent"/>	State <input type="text" value="Delaware"/>		
City <input type="text" value="Bear"/>	ZIP Code <input type="text" value="19701"/>		
Primary Phone <input type="text" value="(555) 555-5555"/>	Secondary Phone <input type="text" value="() - - -"/>	Email Address <input type="text" value="email@email.co"/>	
<input type="radio"/> Male <input checked="" type="radio"/> Female		Date of Birth <input type="text" value="09-05-1999"/> <i>(Must be 18 or Older)</i>	

Patient's Attestation Statement

By signing below, the Patient certifies that the information on this application is complete, true, and submitted for the purpose of obtaining a State of Delaware Medical Marijuana Patient Registry Card. If approved for the Registry Card, the Patient acknowledges receipt of and agrees to the terms of the Delaware Medical Marijuana Act, Title 16 of the Delaware Code, Chapter 49A.

To ensure confidentiality, information regarding application status will not be given over the phone.

* Once applications are processed, communication will be sent to the Patient's residence with further instructions for the finalization of the Registry Card.

* Applicants/patients are required by law to notify DPH Office of Medical Marijuana with any changes in information within 10 days of the change. Failure to do so can result in fines.

* Any registry card that is lost or stolen must be reported to DPH Office of Medical Marijuana immediately.

* Patient information changes that are printed on the Registry Card (such as name or address) will require a new card issued.

- ☐ I hereby certify that all of the information provided on this application is true and accurate to the best of my knowledge.
- ☐ I agree to notify the Medical Marijuana Program, in writing, within 10 days of any changes to the information provided.
- ☐ I attest that I will not divert marijuana to any individual or entity that is not allowed to possess marijuana pursuant to Title 16 of the Delaware Code, Chapter 49A.

Patient's Signature

Read the statement and check the applicable boxes before inputting the patient's signature. The next section is the Physician Certification:

Physician Certification

PATIENT'S INSTRUCTIONS: Have your physician complete this entire section. This section should be submitted with your completed application to the Medical Marijuana Program – partial applications will not be accepted. **The patient application must be received by the Division of Public Health Medical Marijuana Office, within 90 days of the physician's signature date.**

NOTE: THIS DOES NOT CONSTITUTE A PRESCRIPTION FOR MARIJUANA.

PHYSICIAN'S INSTRUCTIONS: Print clearly and answer all of the questions with information in the patient's medical record.

Fill in the First and last name of the Physician that will be **certifying** your medical marijuana application.

Physician Information

Q Match

Last Name

First Name

Middle Name

Address (Street)

Address (Apt #, P.O. Box, Suit #)

County

State

City

ZIP Code

Then click the blue Match button. If your doctor is registered the remaining fields will populate.

The physician will need to complete all of fields below through to the physician's signature and comments if applicable.

Physician information

Last Name

First Name

Middle Name

Address (Street)

Address (Apt #, P.O. Box, Suit #)

County

State

City

ZIP Code

Primary Phone

Fax

Email Address

Medical License Number

License State
(Must be licensed in Delaware)

License Type
(Must be DO or MD)

Debilitating Medical Condition

Listed below are the **ONLY** qualifying debilitating medical conditions as stated in Title 16 of the Delaware Code, 4902A (3)

At least one option should be filed

☐ Cancer

☐ Terminal illness

☐ Positive status for Human Immunodeficiency Virus (HIV Positive)

☐ Acquired Immune Deficiency Syndrome (AIDS)

☐ Decompensated Cirrhosis

☐ Amyotrophic Lateral Sclerosis (ALS / Lou Gehrig's Disease)

☐ Chronic or debilitating disease or medical condition or its treatment that produces one or more of the following:

☐ Cachexia or Wasting Syndrome

☐ Severe, debilitating pain that has not responded to previously prescribed medication or surgical measure for more than three (3) months, or for which other treatment options produced serious side effects

☐ Intractable Nausea

☐ Seizures

☐ Agitation of Alzheimer's Disease
 ☐ Severe and persistent muscle spasms, including but not limited to those characteristic of Multiple Sclerosis

☐ Post-traumatic Stress Disorder (PTSD)

☐ Autism with aggressive behavior

Listed below are the ONLY qualifying debilitating medical conditions as stated in Title 16 of the Delaware Code, 4902A (3)

I have established a bona fide physician-patient relationship with (patient) beginning MM-DD-YYYY (date of first patient visit to your office).

This qualifying patient is under my care, either for primary care or the debilitating medical condition listed on this form.

I completed an assessment of the qualifying patient's current medical condition, including presenting symptoms related to the debilitating medical condition I diagnosed or confirmed in accordance with Title 16, Chapter 49A of the Delaware Code (4902A(3)).

I have completed an assessment of the qualifying patient's medical history, including medical records from other treating physicians for the qualifying condition. I have established a medical record of the qualifying patient with regards to the medical condition, continued treatment under my care, and will document follow-up to determine efficacy of the medical marijuana treatment.

I have assessed this patient for history of substance use disorder.

If a history of substance abuse has been identified. The Department of Health and Social Services (DHSS) requests your acknowledgement of the history of substance abuse, and you confirmation that medical marijuana is an appropriate treatment option to include a commitment to monitor patient closely. (Please initial here if indicated).

Physician's Attestation

I (physician), hereby certify that I am a physician duly licensed to practice medicine.

It is my professional opinion that the qualifying patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient's qualifying debilitating medical condition or symptoms associated with the debilitating medical condition. Further, it is my professional opinion that the potential benefits of the medical use of marijuana would likely outweigh the health risks for this patient. I attest that the information provide in this written certification is true and correct.

Physician's Signature (no signature stamps accepted)

Comments: Provide any additional information that would be useful in assessing this patient's application to the Delaware Medical Marijuana Program.

The next section to complete is voluntary demographic information. Optionally input your demographic information by answering the questions using the radio buttons and/or typing the answers in as needed.

Voluntary Demographic Information

Your voluntary answers are requested - check the items that apply. It is the policy of the State of Delaware to assure equal and fair treatment in all aspects of healthcare for all Delaware residents. The information on this page will only be used to document and assess the effectiveness of our outreach and will not be used for eligibility determination. Under the Health Insurance Portability and Accountability Act (HIPAA), personally identifiable information is protected. De-identified patient information is used for research purposes. Aggregate, de-identified patient information can be published and shared with third parties.

☐ Single
 ☐ Married
 ☐ Divorced
 ☐ Separated
 ☐ Widowed
 ☐ Unmarried Partnership

☐ Hispanic or Latino
 ☐ Caucasian / White
 ☐ Asian
 ☐ Native Hawaiian or Pacific Islander

☐ African American / Black
 ☐ American Indian or Alaskan Native
 ☐ Other

How well do you speak English?
 ☐ Very Well
 ☐ Well
 ☐ Not Well
 ☐ Not at All

Do you speak another language other than English at home?
 ☐ No
 ☐ Yes, Spanish
 ☐ Yes, not Spanish, specify

Are you a United States veteran?
 ☐ No
 ☐ Yes

Are you a citizen or lawful resident of the United States of America?
 ☐ No
 ☐ Yes

What is your highest level of education completed?

☐ Some High School Completed
 ☐ High School Diploma / GED
 ☐ Technical School

☐ Community College / 2-Yr Degree
 ☐ University / 4-Yr College
 ☐ Master Program or Above

Are you currently enrolled in school?
 ☐ No
 ☐ Yes, please specify

Are you currently employed?
 ☐ No
 ☐ Yes, part-time
 ☐ Yes, full-time

What is your current occupation?

What is your annual household income?

☐ Less than \$19,999
 ☐ \$20,000 to \$39,999
 ☐ \$40,000 to \$59,999
 ☐ \$60,000 to \$79,999
 ☐ \$80,000 to \$99,999
 ☐ \$100,000 or above

Are you currently enrolled in a public assistance program such as food supplement program or any other?

☐ No
 ☐ Yes, please specify

Next, read the 'Patient Release of Medical Information' instructions and the Patient Release Request. On the release request, input the patient name and **certifying** physicians name and the authorization date in MM-DD-YYYY form into the provided fields. The patient will need to input their signature into the 'Patient's Signature field.

Patient Release of Medical Information

PATIENT'S INSTRUCTIONS: Complete and sign the following release statement. This form will allow the Medical Marijuana Program staff to verify information with the certifying physician(s) relating to your qualified medical condition. This form must be submitted with your patient enrollment application. If this form is omitted, your application will be considered incomplete and will be denied.

Patient Release Request

I (patient),
hereby authorize the Delaware Department of Health and Social Services (DHSS), Division of Public Health (DPH), Medical Marijuana Program (MMP) to discuss my medical condition, including treatment records, test results, and evaluations specific to
 (physician's full name).

I understand that I may revoke this release at any time. I also understand that if I wish to revoke this authorization, I must do so in writing to the Delaware Medical Marijuana Program, and that revocation may result in the inability of the program to certify me as a Medical Marijuana Program participant. Additionally, I understand that the revocation will not apply to the information that has already been released in response to this authorization.

This information disclosed pursuant to the authorization is subject to potential re-disclosure by the recipient, and will not be protected by the HIPAA privacy rule. I understand that this disclosure is voluntary and that signing this form is not necessary in order to receive treatment from the Delaware Department of Health and Social Services. This release is required, however, to verify my eligibility for the Medical Marijuana Program.

By signing this release I certify that I am aware that the program may provide verification of my enrollment status with law enforcement; but only for the purpose of verifying that a person is lawfully enrolled in the Medical Marijuana Program, or in the event that the Medical Marijuana Program administrator or designee has reason to believe that a qualified patient-applicant may have violated an applicable law.

This authorization will expire one (1) year from the date signed below unless a different expiration date, less than one (1) year, is specified here:

Patient's Signature

Patient Application Checklist

☐ Did you initial all three of the Patient Attestation Statements and sign on the signature line?

☐ Did you include the Physician Certification forms completed and signed by your physician?

☐ Did you sign the Release of Medical Information form?

☐ Did you include a legible copy of your Delaware driver's license or state-issued identification?

☐ Did you include the \$125.00 non-refundable application fee or your signed Low Income Charge Request form with supporting documentation? Please make check or money order payable to State of Delaware, MMP

Application Fee Amount \$

Application Fee paid






Finish the patient application by reviewing each item and checking the box next to it once complete. Make sure to upload a legible copy of your Delaware driver's license or state-issued identification by clicking on the +Upload button.

Payment - The State of Delaware Office of Medical Marijuana cannot process your application until the \$125 application fee OR the Fee Waiver Form and documentation have been received.

Please remit check or money order payment to:
Delaware Division of Public Health
ATTN: MMP, Suite 130
417 Federal Street
Dover, DE 19901

For faster processing, remit payment online:
Pay online by logging into your account

Own Applications

Barcode	Application	Percentage	Expiration Date	Action
	 Pending Patient Application	100%		 Preview  Renewal  Replace

Remit payment to:

Delaware Division of Public Health
ATTN: MMP, Suite 130
417 Federal Street
Dover, De. 19901

Please include Application Barcode into payment description or Pay Online.



If you cannot afford the full payment, please fill out the State of DE MMJ Fee Waiver Form which is provided on the Delaware Medical Marijuana page or within your application
<http://dhss.delaware.gov/dhss/dph/hsp/files/mmpfeewaiver.pdf>

Finally, click on the Submit button to send the application. If you receive an error message after clicking submit, check over the application, enter any missing information and resubmit the application.